

Health,
& Welfare
Public
Service

S. 300
v. 1-57 D

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

348
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

393551

STATE FILE NUMBER

1203

FILED NOV 18 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1203

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Meth. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u> c. CITY OR TOWN <u>Grant City</u> d. STREET ADDRESS (If outside, give location) <u>1130</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vera</u> Middle <u>Irene</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 11, 1910</u>	
9. AGE (In years) <u>47</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (City and state or country) <u>Grant City, Mo.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (City and state or country) <u>Grant City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Forrest Fattig</u>		13b. MOTHER'S MAIDEN NAME <u>Lillie Rowen</u>		14. NAME OF HUSBAND OR WIFE <u>Lloyd J. Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Mr. Lloyd J. Thompson, Grant City, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aneurysm, cerebral artery - left</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>aneurysm of cerebral artery</u> DUE TO (c) <u>5 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>330X</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <u>4:45p.</u> Month, Day, Year <u>Oct 9, 1957</u>							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Oct 9, 1957</u> to <u>Oct 14, 1957</u> and last saw her <u>alive on</u> <u>Oct 14, 1957</u> Death occurred at <u>4:45p.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>H. E. L. L. L.</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>St. Joseph Mo</u>		22c. DATE SIGNED <u>10/28/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>10/15/1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Honey Grove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Grant City, Mo.</u>	
24. FUNERAL DIRECTOR <u>Heaton-Bowman</u>		ADDRESS <u>St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 31, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>	

(Licensed Embalmer's Statement on Reverse Side)

JUN 23 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *William J. Galt*

Licensed Embalmer No. *4035*

P. O. Address *245 1st St. N. P. 1958*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.